

Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

TrustRX Pharmacy

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-25-1256-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

February 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2024	50228015805 Celecoxib	\$288.30	\$288.30

Requestor's Position

"I have also attached a copy of trustrx W-9 since Trustrx [sic] has terminated its relationship with Injury billing. Payment should be made out to Trustrx Pharmacy."

Supplemental response submitted April 16, 2025

"Trustrx has not received payment or a new EOB for the above date of service. Trustrx would like to proceed with the medical fee dispute."

Amount in Dispute: \$288.30

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized the review."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.503](#) sets out the fee guidelines for pharmaceutical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- P6/5028 – Based on entitlement to benefits
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 112 – Service not furnished directly to the patient and/or not documented
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 252 – An attachment documentation is required to adjudicate this claim/service

Issues

1. Is the insurance carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for prescribed medication dispensed on May 1, 2024. The insurance carrier states denied the claim based on entitlement to benefits and incorrect payer, services not documented, and documentation required.

The insurance carrier did not submit documentation to support the denial of the claim as indicated on the EOBs or a position statement to support these denials. As a result, due to the insufficient documentation the DWC will proceed with the audit of the disputed charges.

2. DWC Rule 28 TAC §134.503 (c) states the insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

- Generic drugs: $((AWP \text{ per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount

Drug	NDC	Generic (G)	Quantity	AWP /unit	DWC Fee	Billed Amount	Lesser of DWC Fee and Billed Amount
Celecoxib	50228/015805	G	30	7.58	\$288.30	\$288.30	\$288.30
TOTAL					\$288.30	\$288.30	\$288.30

The DWC finds that the requestor is entitled to reimbursement, in the amount of \$288.30.

Conclusion

The outcome of each independent medical fee dispute relies on the relevant evidence the requester and respondent present at the time of adjudication. Although all the evidence in this dispute may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is due. As a result, the amount ordered is \$288.30.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that the New Hampshire Insurance Co must remit to the Trustrx Pharmacy \$288.30 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 29, 2025
Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the

instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3, or email CompConnection@tdi.texas.gov. The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.